U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 30May2001

Case No.: 2000-LHC-1214

OWCP No.: 01-139568

In the Matter of:

JOHN J. WASSON,
Claimant

against

BATH IRON WORKS CORPORATION,
Employer

APPEARANCES:

JAMES W. CASE, ESQ.,
On behalf of the Claimant

STEPHEN HESSERT, ESQ.,
On behalf of the Employer

BEFORE: RICHARD D. MILLS
Administrative Law Judge

DECISION AND ORDER AWARDING BENEFITS

This is a claim for benefits under the Longshore and Harbor Worker's Compensation Act (hereinafter "the Act"), 33 U.S.C. § 901, et seq., brought by JOHN J. WASSON ("Claimant") against BATH IRON WORKS CORPORATION ("Employer") for injuries allegedly sustained during the construction of a vessel.

The issues raised here could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. A formal hearing was held September 12, 2000 at Portland, Maine.

STIPULATIONS

Prior to the hearing, the parties agreed to a joint stipulation (TX, p. 11):[1]

1. Claimant was employed in the construction of vessels at a shipyard adjacent to navigable waters;

2. An Employer/Employee relationship existed between the Claimant and the Respondent at the time of the alleged injury;

3. Claimant suffered an injury to his spine on December 9, 1996;

4. Claimant's claim was timely filed and the Employer gave timely notice of controversion;

5. Compensation was paid in the following amounts:

Temporary Total Disability from 1/16/1997 until 5/2/1997
Temporary Total Disability from 5/6/1997 until 1/22/1998
Temporary Partial Disability from 2/13/1998 until 2/17/1998
Permanent Total Disability from 2/18/1998 until 8/25/1998
Reduction to Permanent Partial disability on 8/25/1998;

6. Claimant's average weekly wage at the time of his injury was $672.87.

ISSUES

The parties listed the following issues as disputed on the joint stipulation:

1. The causation of the Claimant's pseudo tumor cerebri;

2. The nature and extent of the Claimant's disability;

3. Employer's liability for medical expenses of the Claimant;

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[1] The following references will be used: TX for the official hearing transcript; JX-__ for Joint exhibits; CX-__ for the Claimant's exhibits; and RX-__ for Employer's exhibits.

4. Attorney's fees

SUMMARY OF FACTS

I. Claimant's Employment

The Claimant testified at hearing that he began working for Employer in November of 1988. (TX, p. 25). Claimant testified that at that time he had recently been discharged from service in the U.S. Marine Corps. (TX, p. 25).

Claimant worked for Employer from November of 1988 until the date of his injury in December of 1996. (TX, p. 26). During this time, Claimant worked as a preservation technician. (TX, p. 26). Claimant described this position as a person in the paint department who would clean an area and get it ready for work including preparing surfaces for painting by getting rid of rust, chipping paint, and feathering them out. (TX, p. 26). The position was also responsible for painting either with brushes or with air sprayers and masking the surfaces that were not to be painted. (TX, p. 27). He testified that most of the time this work was performed on ships. (TX, p. 27).

During his tenure at Employer, Claimant was assigned to work on all areas of the ships he worked on from the bilge tanks to the pilot house. (TX, p. 27). He testified that he frequently worked in confined spaces because of his size and the fact that many other technicians were claustrophobic. (TX, p. 27).

Claimant testified that in the final months of 1996 they were working in the shaft alley on a ship. The other work crews had already removed the staging from this area, and Claimant's crew was assigned to finish the painting where the staging had left bare metal and rust. (TX, p. 28). Claimant testified that at the time they could not use ladders or staging to do the work. That forced him to work by hanging in the work space by his arms while he painted. (TX, p. 28-29). Claimant testified that he developed a sore neck and arm from working overhead in this fashion. (TX, p. 29). He stated that he worked in this fashion for approximately one week. (TX, p. 30).

Claimant testified that when his shoulder and back started to hurt he mentioned it to his lead man. (TX, p. 34). He kept working under these conditions for a few days. On December 9, however, the pain was so severe that he could not use his arm. That day the lead man sent him to the company medical facility. (TX, p. 35). Claimant saw Dr. Mazorra that day and was referred to physical therapy in the yard facility. (TX, p. 36). The course of physical therapy lasted approximately one month and the Claimant continued to work at light duty during that time. (TX, p. 37). Claimant's condition did not improve with therapy. (TX, p. 37).

Approximately one month after the Claimant's injury, he consulted his family physician, Dr. Oswald.

Oswald took him out of work in the middle of January of 1997. (TX, p. 38). He was also referred by Dr. Caldwell, who worked for the Employer, to a specialist named Dr. Ayers. (TX, p. 38). Claimant testified that Ayers is an orthopedic surgeon who consults for Employer. (TX, p. 38). Claimant saw Dr. Ayers around the 21st of January, 1997. At that time he was given certain

restrictions to follow during his daily routine. Based on those restrictions, Employer told Claimant that it had no further work for him at that time. (TX, p. 39).

II. Claimant's Medical Treatment

A. Dr. Mazorra

Employer's Exhibit 24 are the medical records from the Employer's on site medical facility related to this injury. They indicate that on December 10, 1996, Claimant reported to Dr. Maria Mazorra of the medical staff at Bath Iron Works. Dr. Mazorra examined the Claimant, determined that he suffered from cervical and trapezius strains from working in tight spaces, and prescribed treatment at the on site physical therapy facility. (EX-24, p. 84). The doctor also restricted the Claimant from kneeling, crawling, stooping, confined space and overhead work, lifting or carrying more than 20 pounds. (EX-24, p. 84).

The Claimant reported to the yard's physical therapy division and received massage therapy. He was also treated with a non-steroidal anti-inflammatory drug (NSAID) and with a muscle relaxant. (EX-24, p. 79). Over the course of the next week, Claimant continued to guard his muscles on physical examination. He also continued to report that he felt better with medication and therapy but that the results of those treatments were not long lasting. (EX-24, p. 77). On December 19, the Claimant appeared at the yard medical facility and was instructed in the use of the TENS unit. He was then given one of these units for home use. (EX-24, p. 76).

In January of 1997, the Claimant reported to the yard medical staff that he felt he was not improving with treatment. The staff then suggested to the Claimant that he might seek assistance from another doctor. (EX-24, p. 74). On January 13, 1997, the Claimant reported that his doctor had taken him out of work temporarily and that he was currently not participating in physical therapy pending instructions from his doctor. (EX-24, p. 73).

B. Dr. Oswald

Claimant saw his family doctor, Dr. Oswald, in January of 1997. Following his initial examination, Dr. Oswald determined that the Claimant's back and neck pain was likely secondary to cervical dysfunction. He also noted that inflammation of the levator scapulae and the possibility of discopathy and radiculopathy might also contribute to the Claimant's symptoms. (EX-31, p. 191). Claimant was given a prescription for Daypro and Norflex and was instructed to take one week off of work. He was instructed to return for re-evaluation at that time. (EX-31, p. 191).

Claimant returned to Dr. Oswald on January 22, 1997. At that time he had been evaluated by an orthopedist and had x-rays taken of his back and neck. Oswald noted that there was a question of a bone spur in his neck causing some of his symptoms. Claimant also advised that he had stopped taking the Daypro because it made him ill. He had also stopped taking the Norflex. (EX-31, p. 189). Dr. Oswald advised the Claimant to follow up with his orthopedist and strongly encouraged him to continue taking the Norflex. He also recommended use of a heating pad and stretching exercises. (EX-31, p. 189).

On January 30, 1997, Claimant saw Dr. Oswald again. At that time, Oswald noted that the Claimant had been diagnosed with chronic disk herniations as well as cervical compression neuropathy. (EX-31, p. 188). Claimant was undergoing therapy at that time and had resumed use of the Norflex and Daypro. Dr. Oswald advised him that he needed to lose weight and determined that his back pain was due to degenerative disk disease and disk degeneration. (EX-31, p. 188).

Dr. Oswald does not include further notes on his treatment of the Claimant for this injury. There are notes detailing other procedures and visits between the Claimant and Dr. Oswald, but none related to his neck pain.

C. Dr. Ayers

On January 21, 1997, Claimant was referred to Dr. John Ayers by the medical staff at BIW. Ayers examined the Claimant at Employer's facility and noted that X-rays showed Claimant had a mild narrowing of the C5-6 and prominent C7 transverse processes. He also found that Claimant had some anterior spurring in the shoulder. Lumbar films taken that day were normal. (EX-22, p. 46). Based on these findings, Ayers determined that the Claimant had some elements of shoulder tendinitis and muscle strain with occipital neuritis. Ayers stated that if the symptoms continued for more than one month, blood work would be indicated. (EX-22, p. 47).

On February 4, 1997, Dr. Ayers saw the Claimant again at Employer's facility. This time, Ayers noted that Claimant continued to have mid back pain. With no work, however, the Claimant's neck had gotten significantly better. Despite the improvement, Dr. Ayers was concerned about the possibility of a disc injury to the mid-back or a less likely facet injury. Since both of these would be shown by a current MRI, Ayers ordered the performance of that test on the Claimant. (EX-22, p. 43).

When Claimant had his MRI results on February 25, 1997 he again saw Dr. Ayers. Ayers indicated that the MRI showed multiple levels of disc rupture that Dr. Ayers thought were of only minor importance. Based on the MRI, Ayers referred the Claimant for a neurosurgical evaluation to determine if his disc injuries could be improved through surgery. (EX-22, p. 41). Dr. Ayers referred the Claimant to Dr. White for consultation regarding this possibility.

D. Dr. White

Claimant first saw Dr. White pursuant to the referral of Dr. Ayers on March 18, 1997. Following that visit, White reported to Ayers that the Claimant's symptoms might represent a disk herniation at the C5-6 level. (EX-33, p. 258). Without the evidence of a C6 radicular syndrome, however, White stated that he would not pursue surgical intervention. Instead, he recommended aggressive physical therapy and an emphasis on stretching and flexibility. (EX-33, p. 259).

Doctor White saw the Claimant again on June 4, 1997. On that day he noted the Claimant had developed increasing stiffness in his neck. Claimant had thus had a cervical spine MRI as ordered by Dr. Mazorra at Employer's facility. This MRI showed a lateral disc herniation at C6-7 on the right side. The Claimant told Dr. White that he had a substantial easing of his pain over the past few weeks. Based on this assessment, Dr. White opined that the need for neurosurgical intervention was unlikely. (EX-33, p. 256).

On March 12, 1998, Claimant returned to see Dr. White again. This time Claimant indicated to Dr. White that he had returned to work about two months prior to his visit. Claimant had gradually developed increasing pain and stiffness in his neck and right arm. Claimant indicated that he had treated with Dr. Daigle prior to returning to work and that these treatments had been very helpful. The nature of recent MRI findings led Dr. White to conclude that the continued nonsurgical course was best. He agreed to see the Claimant again in four weeks to reevaluate this decision. (EX-33, p. 254).

By April 14, 1998, Claimant's symptoms had not improved. Dr. White told the Claimant that, because of the duration of his symptoms and the severity of his radicular pain, he thought the Claimant was a candidate for cervical surgery. He agreed to see the Claimant regarding the surgery option in eight weeks. (EX-33, p. 252).

In June of 1998, Claimant returned to Dr. White. He was now showing a positive impingement syndrome in his right shoulder and minimal pain against external rotation of the right arm. Dr. White felt that these symptoms indicated the need for cervical surgery. He also determined that Claimant should be referred to an orthopedic surgeon for consultation about his right shoulder. (EX-33, p. 250). Dr. White referred the Claimant to Dr. Dumont.

Subsequently, the Claimant was admitted to the hospital by Dr. White for cervical discectomy at the C6-7 level on the right side. (EX-33, p. 247). The surgery was performed on July 20, 1998, and the Claimant apparently tolerated it well. (EX-33, p. 244-245). By August of 1998, Dr. White reported that the Claimant was recovering well from the surgery. (EX-33, p. 241). This progress continued December of 1998 when Dr. White recommended that the Claimant participate in structured rehabilitative exercises with Robert Brainerd. (EX-33, p. 235). On August 11, 1999, Dr. White opined that Claimant had reached maximum medical improvement. (EX-33, p. 229).

E. Dr. Dumont

Doctor Dumont took up the Claimant's care on June 1, 1998. By this time, the Claimant had been

out of work for more than one year. He presented to Dr. Dumont with the progressive onset of neck and right shoulder pain. Dumont notes in his initial evaluation that the Claimant "cannot recall any specific accident but the type of work that he had to do with his dominant right upper extremity, caused progressive pain, stiffness to a point that he had to relieve work." (EX-28, p. 130).

Dumont reviewed the films that were available and examined the patient. Based on this examination, Dr. Dumont opined that the Claimant had some degree of shoulder impingement that was causing his distress. Doctor Dumont chose to treat the Claimant using a subacromial infiltration with steroids. This procedure was performed. Dumont also suggested that if the problem persisted that he might perform a subacromial decompression on the Claimant. (EX-28, p. 130).

The Claimant was reexamined by Dr. Dumont on June 25, 1998. The injections of steroids had helped somewhat and he was seeing a chiropractor, which also helped. Claimant indicated that he did not think he could return to work at that time. Doctor Dumont indicated that there would be no further treatment at that time and that the Claimant would soon have to decide whether he could return to work at Employer's facility or not. (EX-28, p. 129).

The Claimant saw Dr. Dumont again on February 23, 1999. By this time, the Claimant had already had his cervical surgery. Dr. Dumont noted a full range of motion with the exception of a few degrees of motion when the Claimant brought his arm to his back. He also noted that the Claimant had joint and ligament pain at that time. Additionally, X-rays now showed some early spur formation along one of his joints. Doctor Dumont chose to treat the Claimant with an additional infiltration of steroids and Xylocain. (EX-28, p. 128).

Doctor Dumont saw the Claimant again on March 16, 1999 at which time he reported that his shoulder was doing better as long as he did not overly exert himself. Claimant was previously scheduled to see Dr. Esponette for electordiagnostic studies of his shoulder. Pending the outcome of those studies, Dr. Dumont suggested that an arthroscopy of the Claimant's shoulder might be appropriate. (EX-28, p. 127). When claimant returned after these tests in May of 1999, Dr. Dumont opined that at this point he required medical pain management. He also stated that it was unlikely that the Claimant would be able to return to work at Employer's facility in the same capacity and opined that the Claimant might be suffering from the onset of depression. (EX-28, p. 126).

F. Dr. Esponette

The Claimant was also seen beginning in October of 1998 by Dr. Peter Esponette for electrodiagnostic testing and rehabilitation. Following their first meeting on October 27, 1998, Dr. Esponette reported that Claimant suffered from a variety of injuries resulting in his neck, lower back, and shoulder discomfort. Specifically, Claimant had a history of C7 radiculopathy, a C6-7 decompression and fusion, chronic impingement syndrome in his right shoulder, local muscle guarding, and chronic pain

syndrome. (EX-29, p. 158). Esponette explained that the Claimant had seen a large variety of physicians and that he was implementing further treatment reluctantly.[2] Nevertheless, Esponette referred the Claimant to Dr. Gray for pain management and also ordered a repeat course of physical therapy. (EX-29, p. 158).

Claimant saw Dr. Esponette again on December 8, 1998. At that time, Esponette indicated that the Claimant was rapidly reaching the point of maximum medical improvement. He suggested that the Claimant continue with physical and massage therapy and indicated that he would shortly be ready for a functional capacity evaluation. (EX-29, p. 153-4).

Ultimately, Claimant had a functional capacity evaluation on April 5, 1999 which showed that he had the ability to lift and carry 15 pounds occasionally and an unknown quantity frequently. Claimant was also able to push up to 30 or 35 pounds occasionally. The Claimant also showed a limited ability to bend/stoop, crawl, climb stairs, and crouch. (EX-29, p. 134). Based on these findings and a physical examination, Esponette determined that the Claimant's condition was related to his muscular guarding and some level of chronic pain syndrome. Dr. Esponette also opined that the Claimant might have some derangement of the shoulder to be treated by Dr. Dumont. Esponette suggested that at Claimant's request he could be referred to St. Mary's Center for Pain Management. (EX-29, p. 135).

Claimant last saw Dr. Esponette on May 18, 1999. At that time he had recently seen an ophthalmologist who indicated that the Claimant was suffering blurred vision because of papilledema. He had then been scheduled to see Dr. Kahn for a neurological evaluation. (EX-29, p. 131). With respect to his previous injury, however, Esponette indicated that the Claimant had reached maximum medical improvement as of this date. He was informed that Dr. Dumont had already indicated that surgery would not aid the Claimant's condition. Doctor Esponette then reviewed the restrictions indicated by the FCE with the Claimant. According to his notes, he understood that these restrictions would likely prevent the Claimant from returning to work with the Employer. (EX-29, p. 132).

G. Dr. Kahn

In May of 1999 Claimant was referred to Dr. Farrukh Kahn by Dr. White. At that time, Claimant was complaining of headaches and an ophthalmologist had indicated the Claimant suffered from

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[2]Dr. Esponette specifically gave the Claimant's history of medical treatment in his first report. He notes that Claimant saw Drs. Mazorra, Caldwell, and Ayers at Employer's medical facility for assistance. He was then referred to physical therapy. Claimant referred himself to Dr. Daigle, a chiropractor. Then Claimant was referred to Dr. Phillips, who recommended dropping chiropractic treatment in favor of physical therapy. He then referred himself back to Dr. Daigle. Doctor White removed bone spurs from his shoulder. Then he saw Dr. Dumont for shoulder injections. He continued to see Dr. White on a monthly basis for follow-up treatment, but did not participate in therapy or take chiropractic or massage treatments. (EX-29, p. 156-157).

papilledema. Doctor Kahn admitted the Claimant to Central Maine Medical Center for a 23 hour hold so that a lumbar puncture could be performed. (EX-39, p. 363).

When the lumbar puncture was performed on May 25, 1999, Dr. Kahn determined that the Claimant was suffering from pseudotumor cerebri. Kahn notes that the opening pressure of the spinal fluid during the lumbar puncture was about 395 milliliters of water. The closing pressure was 200. (EX-39, p. 362).

The Claimant was started on treatment for this condition on June 3, 1999. At that time, Dr. Kahn prescribed Diamox and instructed the Claimant to follow up with his ophthalmologist for any changes in his visual fields. Kahn also instructed the Claimant to follow up with him in two weeks. (EX-39, p. 358). When the Claimant saw Kahn again on June 16, 1999 it was determined that a repeat lumbar puncture was needed. (EX-39, p. 357). That examination also indicated that the Claimant suffered from pseudotumor cerebri. The Claimant's closing spinal pressure was 180 millimeters of water. (EX-39, p. 356).

The Claimant had a third lumbar puncture performed by Dr. Kahn on August 3, 1999. This puncture also showed that the Claimant was suffering from pseudotumor cerebri. The closing pressure for this puncture was 200 mm of water. (EX-39, p. 354). Claimant was offered the opportunity by Dr. Kahn to seek a second opinion.

H. Dr. Hedges

Claimant was ultimately referred to Dr. Thomas Hedges for evaluation and treatment of his papilledema and pseudotumor cerebri. Hedges saw the Claimant in August of 1999. In his letter following that visit, Hedges explained that the Claimant's age and condition required that he rule out an arteriovenous malformation (AVM). He therefore scheduled the Claimant for an angiogram. (EX-41, p. 378-379).

Claimant saw Dr. Hedges again on September 21, 1999 for reevaluation. At that time, Hedges opined that the Claimant was not a candidate for optic nerve sheath decompression surgery. Dr. Hedges explained that Claimant's visual condition had shown significant improvement and that the surgery would put the Claimant's remaining vision at significant risk. Dr. Hedges also noted elevated vitamin A levels at the time of the Claimant's liver function tests and indicated that improving this condition might also improve the Claimant's pseudotumor symptoms. With that, Hedges released the Claimant from treatment. (EX-41, p. 369).

Post-trial the parties introduced Dr. Hedges deposition testimony in this matter. Hedges explained that pseudo tumor cerebri is an increase in pressure inside the skull caused by increasing pressure of cerebro-spinal fluid. (Depo. of Hedges at 7). He indicated that doctors consider the normal level of pressure to be between 50 and 150 millimeters of water. (Depo. at 11). In this case the Claimant had an opening pressure when Dr. Hedges saw him of 395. Hedges testified that this was a clear indication of pseudotumor. (Depo. at 11).

Doctor Hedges also explained in his deposition that the appropriate treatment for pseudotumor was the use of Diamox to reduce the spinal fluid and therefore the pressure. (Depo. of Hedges at 20). In his opinion, the Claimant's pseudotumor condition is not related to his work place neck injury. Hedges explained that one reason for this was because he could not be entirely clear as to whether the Claimant's headaches were due to his shoulder pain or to his pseudotumor or both. (Depo. at 23). The other reason that Hedges gave for this opinion was that patients with pseudotumor cerebri typically do not develop it as a result of vertebral bone disease.[3] According to Dr. Hedges, there is no medical evidence or literature to support a connection between the Claimant's pseudotumor cerebri and his previous neck injury and cervical fusion. (Depo. at 29-30).

DISCUSSION

I. Jurisdiction

The parties to this case do not contest the Court's jurisdiction. The Claimant was a preservation technician at Employer's shipyard when he began to experience his neck and shoulder symptoms. He worked aboard vessels in the water alongside the Employer's facility in Maine. The Court finds that the Claimant was an employee within the meaning of section 902 (3) of the Act. We also find that the Claimant was employed in a maritime location (a shipyard and dry dock) with respect to section 903(a) of the Act. *See* 33 U.S.C. § 902, 903.

II. Claimant's Prima Facie Case

To receive compensation under the Act, the Claimant must make out a prima facie case that he was injured within the course and scope of his employment and that this injury has resulted in a disability. In order to make out the prima facie case, the Claimant must demonstrate that he suffered some harm or pain. *See Murphy v. SCA/Shayne Brothers*, 7 BRBS 309 (1977), *aff'd mem.*, 600 F.2d 280 (D.C. Cir 1979). The Claimant must also demonstrate that an accident occurred or working conditions existed which could have caused the pain or harm. *See Kelaita v. Triple A. Mach. Shop*, 13 BRBS 386 (1981).

In this case, claimant asserts that he suffered significant back, neck, and shoulder pain as a result of his work for the Employer. Claimant presents various medical records as evidence in this case and Employer provides essentially parallel records. These documents and the Claimant's testimony tend to show as we have explained in detail above that on or about December 9, 1996, the Claimant began to suffer from back and neck pain. (TX, p. 35; EX-24, p. 84). As demonstrated by the medical records from Employer's medical facility, Claimant reported to the facility and sought treatment for his symptoms.

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[3]Dr. Hedges indicated that there are patients who have pseudotumor cerebri as a result of spinal tumors. However, he felt that the number of X-rays and other studies of the Claimant's neck were sufficient to rule out this possibility. (Depo. of Hedges at 29).

(EX-24).

The medical records presented also show that in May of 1999 Claimant began to experience headaches and other discomfort. He was referred to both an eye doctor and to a neurologist for evaluation. Through this course it was determined that he suffered from papilledema and

pseudotumor cerebri. (EX-39, p. 362-363). As explained by Dr. Hedges, pseudotumor cerebri would cause a person to suffer from intense headaches, pulsation sounds in the head, and occasionally neck pain or more localized pain. (Depo. of Hedges p. 9).

The Court has fully considered the medical evidence in this case and the Claimant's testimony. Based on this evidence the Court finds that the Claimant undeniable suffered from some harm or pain as a result of his employment with the Employer. The Claimant has therefore made out the first part of his prima facie case.

The second part of the section 20(a) test is that the Claimant must prove that an accident occurred or working conditions existed which caused the harm or pain. Considering the Claimant's description of his working environment the week before his pain started, the Court finds that working conditions certainly existed which could have caused the Claimant to suffer from neck and shoulder pain. (TX, p. 28-30).

With respect to the Claimant's headaches and pseudotumor cerebri, the Court is in a difficult position. The only physician to testify about this condition, Dr. Hedges, testified that the condition was probably not related to the Claimant's neck injury. (Depo. of Hedges at 23, 29-30). Hedges also testified that pseudotumor cerebri is sometimes referred to as idiopathic intracranial hypertension. According to him, this means that the cause of the increased pressure in the skull is unknown. (Depo. of Hedges at 7).

The Court has found virtually no case law dealing with this type of idiopathic injury. The question of how we should deal with it with respect to the prima facie case is apparently one of first impression. As we read it, Dr. Hedges learned medical opinion is only that this condition is probably not a natural result of the Claimant's neck and shoulder injuries. The equivocal language of Hedge's opinion, however, leaves open the possibility that working conditions could have caused the harm or pain. We therefore invoke the presumption in favor of the Claimant.

Once the Claimant has met his burden and the presumption is invoked, it is Employer's burden to go forward with substantial evidence that the injury did not arise out of the Claimant's employment. *See Swinton v. J. Frank Kelly, Inc.*, 554 F.2d 1075, 1082, 4 BRBS 466, 475, (D.C. Cir.), *cert. denied*, 429 U.S. 820 (1976). In this case, the Court finds that the Employer has presented no evidence that tends to rebut the presumption. Employer in their brief argues only that the Claimant's pseudotumor cerebri is not compensable. We disagree. Employer does not contest the fact that Claimant suffered other injuries to his neck and shoulder which are related to his workplace environment and for which he should be

compensated. As best we can tell, the pseudotumor could be related to these other harms. The Court therefore finds that with respect to the workplace injury, the Employer has not rebutted the presumption.

III. Nature and Extent of Disability

Employer and Claimant primarily dispute the current nature and extent of the Claimant's disability. Employer urges that the Claimant is at worst partially disabled and proffers proof of suitable alternate employment. Claimant contends that he is totally disabled and that no suitable alternative is available.

The law holds that the Claimant's residual disability, partial or total, will be considered permanent if and when the employee's condition reached a point of maximum medical improvement. *James v. Pate Stevedoring Co.*, 22 BRBS 271, 274 (1989). In this case, the Court finds that the Claimant has reached maximum medical improvement. Doctor Esponette put the date of maximum medical improvement for the Claimant at May 18, 1999. (EX-29, p. 131). Doctor White also opined that the claimant had reached maximum medical improvement. He put the date of MMI at August 11, 1999. (EX-33, p. 229). Based on this evidence, the Court concludes that the Claimant has reached maximum medical improvement and that his residual disability is therefore permanent in nature. The Court finds that the Claimant reached maximum medical improvement as of August 11, 1999.

The law declares a Claimant's disability to be total in extent when the Claimant loses the ability to earn pre-injury wages through his pre-injury employment or any other employment. Initially, the Claimant must prove that he cannot return to his previous employment. The Court must consider the Claimant's medical restrictions in comparison to the requirements of his usual job. *Curit v. Bath Iron Works Corp.*, 22 BRBS 100 (1988).

The Employer in this case concedes that the Claimant is unable to return to his prior shipyard employment. The Court finds that the Claimant has the ability to lift and carry 15 pounds occasionally and an unknown quantity frequently. Claimant was also able to push up to 30 or 35 pounds occasionally. The Claimant also showed a limited ability to bend/stoop, crawl, climb stairs, and crouch. (EX-29, p. 134). The Claimant's previous employment involved working in confined spaces, crawling, kneeling, bending, and crouching. It also involved suspending the Claimant's own weight from one arm while painting and performing other tasks. (TX, p. 27-29). Based on this evidence, the Court is satisfied that the Claimant cannot perform his usual job as a preservation technician.

The burden then shifts to the employer to show that suitable alternative employment is available. This means that Employer must show the existence of realistically available jobs within the geographic area where the Claimant resides. Further, Claimant must be capable of performing these jobs given his age, work experience, education, and physical restrictions and must be able to secure the employment through diligent job search efforts. *Lucas v. Louisiana Ins. Guaranty Assn.*, 28 BRBS 1 (1994). The First Circuit, in which this case takes place modifies this burden substantially. That Court has held that when it is obvious that there are available jobs that someone of Claimant's age, education, and experience could

do the Employer is not required to prove the actual availability of suitable alternative jobs. *Air America v. Director, OWCP*, 597 F.2d 773, 10 BRBS 505 (1st Cir. 1979).

In this case, the Court finds that there are no obviously available jobs that the Claimant can perform. Claimant's condition presents a unique set of circumstances that the Court must consider with respect to any proposed alternative. Employer here urges the Court to consider the suitability of alternative jobs proposed in a labor market survey by Memana Abraham on March 22, 2001. (CX-24, Exhibit 2). Mr. Abraham's deposition was taken post-hearing and submitted to the Court as Claimant's Exhibit # 24. Based on the testimony of Mr. Abraham, the Court holds that his labor market survey is seriously flawed and of questionable merit and chooses to disregard it.

Specifically, Abraham testified in his deposition that he based his labor market survey in part on the understanding that the Claimant had certain restrictions related to his vision problems. (CX-24, p. 10). Abraham testified that after reading the deposition of Dr. Hedges, he understood that the Claimant had occasional vision impairments that would prevent him from operating dangerous machinery or working at heights. (CX-24, p. 10). The Court notes that Dr. Hedges actually testified that the Claimant might want to avoid significant lifting as it would make his pseudotumor headaches worse. (Depo. of Hedges at 25). He also testified that he would not tell the Claimant not to drive and that he thought the Claimant probably could operate a fork lift. (Depo. of Hedges at 26-27).

Abraham's labor market survey is further flawed by his reliance on a vague and overly generic understanding of the Claimant's skills and work experience. Abraham testified that he could not find a DOT description of the job of a preservation technician when he performed the survey. Abraham therefore used the generic DOT description of a shipyard laborer to determine what skills the Claimant had. (CX-24, p. 22). He testified that he did not rely on the "Essential Job Skills for a Preservation Technician" supplied by the Employer in this case. (CX-24, p. 22). As a general matter, the Court finds that Abraham's deposition testimony belies the fact that he did not adequately understand the Claimant's job skills or experience with Employer. Moreover, the testimony indicates that he based his labor market evaluation on generic job descriptions and skills which were largely at odds with the Claimant's actual abilities. (CX-24, p. 25-28). Based on these errors, we find the labor market survey prepared by Memana Abraham extremely unreliable. It is not obvious to the Court that there are jobs which the Claimant could perform without exceeding the limits of his physical capabilities. The Court therefore finds that Employer has not successfully proven suitable alternate employment.[4]

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[4]The Court notes that Employer included an additional labor market survey as Employer's Exhibit 21. This survey was prepared by Lorraine Ketchum at Concentra Managed Care in August of 1999. Although this survey does not appear to rely on the flawed medical data used by Mr. Abraham, there is no accompanying testimony to tell the Court what parameters were used in developing the study. Additionally, Employer does not argue that we should rely on the results of this labor market survey in making our decision. Because the Memana Abraham survey is more recent and accounts for

IV. Medical Expenses

Employer and Claimant finally contest the Employer's liability for medical expenses in this case. The Claimant is entitled to medical benefits which are reasonable and necessary to the treatment of the Claimant's work related injury. *33 U.S.C. § 907(a)*. Employer explicitly accepts in its brief the compensability of the case along with related medical expenses and lost time. *Emp. Brief* at 6.

The court has already found that the Claimant's injuries are compensable. Medical expenses to treat these injuries are reasonable and necessary. Because the Employer has conceded their compensability and responsibility for medical expenses, the Court finds that the Employer is responsible for these charges.

ORDER

1. Claimant was temporarily totally disabled from 1/16/1997 until 5/2/1997, and from 5/6/1997 until 1/22/1998 and temporarily partially disabled from 2/13/1998 until 2/17/1998. He was Permanently partially disabled from August 11, 1999 until the present and is entitled to compensation based on Claimant's stipulated Average Weekly Wage of $672.87 in accordance with the provisions of section 8(b) of the Act. *33 U.S.C. § 908(b)*;

2. Respondent shall pay for or reimburse the Claimant for all reasonable and necessary medical care and treatment related to his injuries;

3. Employer is entitled to a credit for any previously paid compensation benefits;

4. Employer shall pay Claimant interest on any accrued unpaid compensation benefits. The interest rate shall be equal to the coupon issue yield equivalent (as determined by the Secretary of the Treasury) of the average auction price for the last auction of 52 week United States Treasury Bills as of the date this Decision and Order is filed with the District Director;

5. Claimant's counsel having filed an attorney fee petition and simultaneously serve a copy of the petition, Employer shall have 20 days to respond to the petition.

So ORDERED.

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substantially all of the Claimant's medical history, the Court chooses to rely on t as the only indication of suitable alternative employment at this time.

RICHARD D. MILLS
Administrative Law Judge

RDM/ct